WHITE PLAINS HOSPITAL
OUTPATIENT REHABILITATION DEPARTMENT
INTAKE INFORMATION

Name:______________________________ DOB:_____________ Date:______________________

Primary or Preferred Language: _________________________

Reason for Therapy:____

Date of Onset of Current Condition(ie surgery date or date of injury)?__________________

Difficult Activities?____

Goals for Therapy? ____

____

Are you currently receiving any of the following services?

- ◯ No other services
- ◯ Physical Therapy
- ◯ Occupational Therapy
- ◯ Speech Therapy
- ◯ Psychology/Neuropsychology
- ◯ Home Therapy or Nursing Care
- ◯ Therapy at another facility
- ◯ Chiropractic Care

Pain Assessment

Are you experiencing pain? Yes or No

Location: ____

0	1	2	3	4	5	6	7	8	9	10
None	Mild pain range			Moderate pain range			Severe pain range			ER

Please describe the pain(Check each that apply)

_____Sharp Pain

_____ Dull (pain) ache

_____ Throbbing

_____ Tingling/Numbness

_____ Shooting

_____ Burning

How often is the pain present(Check one)?

_____ Constant (100%)

_____ Frequent(75-99%)

_____ Intermittent (25-50%)

_____ Occasional (0-25%)

What movement or position causes the pain to increase/decrease?______________________________

How many times do you wake during the night due to pain?____________________________________

Balance Assessment

Have you fallen in the last 30 days? Y / N

Do you use any assistive devices(cane, walker, etc.)? Y / N If yes, please list:

____

Do you feel like you need help with walking today? Y / N

*****Any "Y" responses to above three questions place the patient at risk for fall and the patient to be offered assistance while in the office.**

OVER→

Patient Name:________________________________ **DOB:**________________

Medical History

◯ Asthma

◯ Sleep Disorder

◯ Cancer

◯ COPD/Lung Disease

◯ Depression or Mood Disorder

◯ Diabetes

◯ Heart Disease

◯ High Blood Pressure

◯ Kidney/Liver Disease

◯ Neurologic Condition (ie MS, Parkinson's)

◯ Osteoporosis or Osteopenia

◯ Osteoarthritis

◯ Rheumatoid Arthritis

◯ Seizures

◯ Stroke

Do you have a pacemaker or any implanted device? Y / N
Past Surgical History- Please list: ____
Current Medications- Please list: ____
Allergies- Please list: ____

Home Assessment

Describe current living situation:____
Do you feel unsafe where you live? Y/N
Has anyone threatened to hurt or control you within the past 12 months? Y/ N
Has anyone physically harmed you within the past 12 months? Y/N
Has anyone failed to take care of you when you needed help within the past 12 months? Y/N

Advance Directive

An Advanced Directive is a document or documentation that allows you to give direction about future medical care or to designate another person(s) to make medical decisions if you lose decision making capacity.
Do you have a Medical Orders for Life-Sustaining Treatment(MOLST) Form? _____ Yes ______ No
Do you have a Health Care Proxy? _____ Yes _____ No
Would you like information regarding a MOLST Form or Health Care Proxy? _____Yes _____ No

Patient Health Questionnaire (PHQ-2)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Patient Signature: ______________________________ Date: _________________
Therapist Signature:______________________________ Date: _________________